UPDATED: Washington State Health Home

Essential Requirements

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Under Washington State's approach, health homes are the bridge to integrate care within existing care systems. A health home is the central point for directing patient-centered care and is accountable for the following:

- Reducing avoidable health care costs, specifically preventable hospital admissions/readmissions and avoidable emergency room visits;
- Providing timely post discharge follow-up; and
- Improving patient outcomes by mobilizing and coordinating primary medical, specialist, behavioral health, and long-term care services and supports.

Health Home Care Coordinators must be embedded in community-based settings to effectively manage the full breadth of beneficiary needs.

Health Home Provider Network – A Health Home provider network is administered by a lead entity. The lead entity contracts with one or more care coordination organizations (CCOs). The provider network must include local community agencies that authorize Medicaid, state or federally funded mental health, long-term services and supports, chemical dependency, and medical services. If the qualified Health Home supports managed care beneficiaries, the provider network must contract will all five Healthy Options managed care organizations contracted with the state. Other examples of providers are Regional Support Networks (RSNs), Community Mental Health Agencies (CMHAs), Area Agencies on Aging, Substance Use Disorder providers, Hospitals, Public Health Districts, Accountable Care Organizations, Medical Homes, Charities, Network Alliances, and community supports that assist with housing.

The Health Care Authority (HCA) and the Department of Social and Health Services (DSHS) have identified specific administrative functions for both lead entities and CCOs. However, our intent is to assure these functions are accounted for in the Health Home qualification process and documented in signed contracts and subcontracts. We are not restricting the accountability of the administrative functions. A qualified Health Home may base those functions on its organizational structure.

Lead Entity Requirements – The lead entity is accountable for administration of the health home. The lead entity:

1. Has experience operating broad-based regional provider networks;
2. Contracts directly with the state as a Qualified Health Home;[1]
3. Provides a toll-free line and customer service representatives to answer questions regarding health home enrollment, disenrollment, and how to access services or request a change to another CCO;
4. Subcontracts with organizations to directly provide the Health Home care coordination services;[2]

[1] Healthy Options MCOs may also serve as Lead Entities as long as the network is qualified by the state.

5. Assigns Health Home beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process:
   a. Uses PRISM or other data systems to match the beneficiary to the CCO that provides most of their services; or
   b. Optimizes beneficiary choice;
6. Maintains a list of CCOs and their assigned Health Home population;
7. Maintains Memoranda of Agreement (MOA) with the organizations that are part of the Health Home provider network. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, referral protocols, and sharing of prior authorizations for hospital stays when applicable.
8. Collects and reports encounters to the HCA;
9. Disburses payment to CCOs based upon encounters;
10. Ensures person-centered and integrated health action planning. This includes providing high touch care management; such as the beneficiary-to- care coordinator ratio and documentation of support staff that complements the work of the care coordinator;
11. Collects, analyzes, and reports financial, health status and performance and outcome measures to objectively determine progress towards meeting Health Home goals.

Care Coordination Organization Requirements – The Care Coordination Organization must:

1. Subcontract with the lead entity;
2. Care Coordination Organization(s) have capacity for 1,000 to 2,000 beneficiaries within their Health Home provider network.
3. Assign a Health Home Care Coordinator to provide health home services;
4. Ensure Health Home Care Coordinators maintain a caseload not to exceed 50:1. The caseload may be adjusted when community health workers, peer counselors or other non-clinical staff is used to facilitate the work of the assigned care coordinator;
5. Ensure Health Home Care Coordinators actively engage the beneficiary in developing a Health Action Plan;
6. Ensure documentation by all staff, including those complementing the work of a care coordinator;
7. Implement a systematic protocol to assure timely access to follow-up care post discharge and to identify and re-engage beneficiaries that do not receive post discharge care;
8. Establish methods to share hallmark events with the Health Home Care Coordinator within established time periods, such as emergency department visits, inpatient hospitalizations, inpatient discharges, missed prescription refills, institutional placement and/or discharge, and the need for preventive care;
9. Use a system to track and share beneficiary information and care needs across providers, to monitor processes of care and outcomes, and to initiate recommended changes in care, as

[2] Contractual relationships between the lead entity and their Care Coordination partners must be developed and in place prior to beneficiary assignment.

necessary, to address achievement of health action goals including the beneficiary's preferences and identified needs[3];

10. Provide 24/7 availability of information and emergency consultation services to the beneficiary;
11. Assure hospitals have procedures in place for referring health home-eligible beneficiaries who seek or need treatment in a hospital emergency department for health home enrollment;
12. Use informed interventions that recognize and are tailored for the medical, social, economic, behavioral health, functional impairment, cultural and environmental factors affecting health and health care choices;
13. Provide health home services in a culturally competent manner that addresses health disparities. Examples of cultural competency:
    a. Interacting directly with the beneficiary and his or her family by speaking their language,
    b. Recognizing and applying cultural norms when creating the Health Action Plan, and
    c. Understanding the dynamics of substance use disorder without judgment,
14. Ensure Health Home Care Coordinators (within the care coordination organization) can discuss with the treating/authorizing entities on an as-needed basis, changes in patient circumstances, condition or health action plan that may necessitate timely, and in some circumstances, immediate changes in treatment or services;
    a. A HIPAA-compliant data sharing agreement must be in place when sharing either hard copy or electronic health information.
    b. The beneficiary must sign a "Health Home Patient Information Sharing Consent Form" before the Health Home Care Coordinator can share protected health information;
15. Ensure Health Home Care Coordinators:
    a. Have access to PRISM, a clinical decision support tool, to view cross-system health and social service utilization to identify care opportunities;
    b. Provide in-person beneficiary health screening and health action planning, using HCA and ADSA standardized and approved screens and Health Action Plan template;
    c. Accompany the beneficiaries to critical appointments when necessary to assist in achieving health action goals;
    d. Coordinate and mobilize treating/authorizing entities as necessary to reinforce and support the beneficiary's health action goals;
    e. Deliver culturally appropriate interventions, educational, and informational materials;
    f. Provide in-person care coordination activities;
    g. Include and leverage direct care workers (paid and unpaid) who have a role in supporting beneficiaries to achieve health action goals and access health care services;
    h. Address the full array of beneficiary needs, as reflected in the implementation of a person-centered Health Action Plan. This includes administering standardized health screening, identifying the root causes for inappropriate or gaps in health care utilization, and making referrals and coordinating communication across systems of care.

[3] Preferences means an informed decision, input into a decision and decisions that have value to the beneficiary.